Burgard

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

01687

Reg. Dist. No. 701

1. PLACE OF DEATH:

County Kent

City or town Fountain — Norton Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Norton Md Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Fountain Norton Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hilda Marie Boyer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 15 1925.

8. AGE:

Years	Months	Days	If less than one day
20	10	22	..... hrs. ..... min.

9. Birthplace Fountain Rural Norton Md

(Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER

12. Name James Boyer.

13. Birthplace Norton Md Rural

MOTHER

14. Maiden name Sedonia Bright

15. Birthplace Norton Md Rural Fountain

16. Informant John Boyer

Address Norton Md Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10 1946 (month) (day) (year)

Cemetery or crematory Fountain

Location Norton Md

18. Funeral director B.R. Hellows

Address Still Pond, Md.

19. Feb 10 1946 (Date rec'd by registrar) J.W. Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946, at 10.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to 2-6 1946

and that I last saw h. alive on Jan 25 1946

	DURATION
Immediate cause of death	
Tuberculosis of the	
Due to intestines	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations resection of part of intestines Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Edward A Burgard M. D. or other

Address Rock Hall Md Date signed 2/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 2021

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred: 412 Cannon

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 412 Cannon

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Agnes Grocka

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife: (Late) Martin Grocka

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 25 1883

8. AGE: Years	Months	Days	If less than one day
62	11	0	...hrs. ...min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER — 12. Name: Joseph Miller

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden name: Cathrina Iwandowski

MOTHER — 15. Birthplace: Poland

16. Informant: Mrs. Cathrine Walsh

Address: 412 Cannon St. Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/28/46 (month) (day) (year)

Cemetery or crematory: Galena

Location: Galena, Kent Co. Md.

18. Funeral director: Wm. F. Williams

Address: Chestertown Maryland

19. Feb. 27, 1946 (Date rec'd by registrar) Clara S. Burns. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1946, at 8:06 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1946 to Feb 25 1946

and that I last saw ... alive on Feb 25 1946

Immediate cause of death	DURATION
Carcinoma	
Due to Rectum & Lower Bowel	
Due to Peritonitis & Edema	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Thos

Address: Chestertown Md. M. D. or Other

Date signed: 2/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89a

01689

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, institution, or street address where death occurred:
Kent and Queen Anne's General Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 124 Washington Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Evelyn Russell Hadaway

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	MARRIED

6.(b) Name of husband or wife: James J. Hadaway
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26, 1899

8. AGE: Years	Months	Days	If less than one day
46	6	15	hrs. min.

9. Birthplace: Chestertown, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Bates Russell
13. Birthplace: Chestertown, Maryland.

MOTHER
14. Maiden name: Lola Kendall
15. Birthplace: Rock Hall, Maryland

16. Informant: Hospital records
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12, 1946 (month) (day) (year)
Cemetery or crematory: Chester Cem.
Location: Chestertown - Kent Co. Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Md.

19. Feb. 11 1946 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10, 1946, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8. 1946 19.. to Feb 10 19.46 and that I last saw h.. alive on Feb 10. 1946 19..

Immediate cause of death	DURATION
Cerebral Thrombosis	3 days
Due to: Hypertension	4 mos
Due to: Arteriosclerosis	3y
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank Hines M. D. or other
Address: Chestertown Md Date signed: 2/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01690

Reg. Dist. No. 203

1. PLACE OF DEATH:
County: Kent
City or town: Rock Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: near Rock Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary M. Leary Hadaway

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John E. Hadaway
6.(c) If alive, give age: 90 years

7. Birth date of deceased (mo., day, yr.): July 20, 1859

8. AGE: Years	Months	Days	If less than one day
87 86	7	2	hrs. min.

9. Birthplace: Kent CO. Maryland (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Columbus A. Leary
13. Birthplace: Kent Co. md.

MOTHER
14. Maiden name: Annie Vickers
15. Birthplace: Kent Co. Md.

16. Informant: John E. Hadaway (husband)
Address: Rock Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 25, 1946 (month) (day) (year)
Cemetery or crematory: Wesley Chapel Cem.
Location: Kent Co. Rock Hall, Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Md.

19. 2/24 1946 (Date rec'd by registrar) S. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 1946, at 6-10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 1 1946, to Feb. 24 1946, and that I last saw h[illegible] alive on February 24 1946

Immediate cause of death	DURATION
Acute Myocarditis	2 days
Due to	
Due to	
Other conditions Chronic Bronchitis	1944

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank W Smith M. D. or other
Address: Chestertown Date signed: 2/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Brice

01691

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bra)

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent

City or town: Kennedyville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Kennedyville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie Catherine Melvin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Lester Melvin

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr 8 1864

8. AGE: Years: 81 | Months: 10 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Woman

11. Industry or business: retired

FATHER — 12. Name: John W Harris

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Lydia Sassaman

MOTHER — 15. Birthplace: Delaware

16. Informant: Mrs Hague

Address: Kennedyville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 19 1946 (month) (day) (year)

Cemetery or crematory: Church yard Methodist

Location: Kennedyville

18. Funeral director: B R Fellows

Address: Still Pond Md

19. Feb 19 1946 (Date rec'd by registrar) William Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17 1946, at 2:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1- 1946, to Feb. 17 - 1946 and that I last saw her alive on Feb 16 - 1946

	DURATION
Immediate cause of death: Uremia	4 days
Due to: Chr. Interstitial Nephritis	10 years
Arterio Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Washington Md Date signed: 2/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01692

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:

County: Kent

City or town: Galena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: KENT.

City or town: CHESTERTOWN

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Ida P. Newcomb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife: Frisby Newcomb

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 18 58

8. AGE: Years	Months	Days	If less than one day
87 ~~85~~	5	3	____ hrs. ____ min.

9. Birthplace: KENT Co. MARYLAND. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: George C Adkinson

FATHER — 13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Ann Adkinson

MOTHER — 15. Birthplace: MARYLAND

16. Informant: Wm. G. Smyth

Address: Chestertown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 18, 1946 (month) (day) (year)

Cemetery or crematory: Chester Cem.

Location: Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Feb. 16 1946 (Date rec'd by registrar) Elizabeth J. Mulford Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16 1946, at 12:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 1945 to Feb. 16 1946 and that I last saw her alive on Feb. 16 1946

	DURATION
Immediate cause of death: Asthma	2 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: L. L. Copeland M. D. or other

Address: Millington Date signed: Feb. 14 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

01693

CERTIFICATE OF DEATH

Reg. Diat. No. 201

1. PLACE OF DEATH:

County Kent

City or town Worton Md Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent

City or town Rural Worton Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. Worton Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carrie Elizabeth Rasin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	Widow

6.(b) Name of husband or wife Isaac Rasin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 2 1871

8. AGE:

Years	Months	Days	If less than one day
94	3	14	..... hrs. ..... min.

9. Birthplace Kent Co
(Town, county, and state)

10. Usual occupation Homes

11. Industry or business

FATHER
12. Name Sam Scott
13. Birthplace Kent Co Md.

MOTHER
14. Maiden name Unknown
15. Birthplace Kent Co Md

16. Informant Ellen Hynson
Address Worton Md Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 20 1946 (month) (day) (year)

Cemetery or crematory Church yard Colored
Location Edesville. Md.

18. Funeral director B R Tolleys
Address Still Pond Md

19. Feb 20 1946 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1946 at 1145 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9 1946, to Feb 16 1946 and that I last saw h.. alive on 2/9/46 19..

Immediate cause of death	DURATION
Cerebral accident	
Hypertension	
Due to Arteriosclerosis	
Chronic Nephritis	
Due to Decompensation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert A Runyard M. D. or other

Address Rock Hall, Md Date signed 2/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

01694

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: L. Clifton Collison
3. (b) Social Security Number: 213-05-7242

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Separated
6.(b) Name of husband or wife: Elizabeth Collison
6.(c) If alive, give age: 37 years
7. Birth date of deceased (mo., day, yr.): August 4, 1909
8. AGE: Years: 36 Months: 6 Days: 10 If less than one day: hrs. min.
9. Birthplace: Caroline Co Md (Town, county, and state)
10. Usual occupation: Farm Hand
11. Industry or business: Farm Protective
FATHER 12. Name: Sam Collison
13. Birthplace: Delaware
MOTHER 14. Maiden name: Emma Williams
15. Birthplace: Queen Anne Co Md
16. Informant: Mrs. Records
Address: Rent Co Home Chestertown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17, 1946 (month) (day) (year)
Cemetery or crematory: Church Hill Cem.
Location: Church Hill, Maryland
18. Funeral director: J. Willis Wells
Address: Chestertown, Md.
19. Feb. 15, 1946 (Date rec'd by registrar) Clara S. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1946, at 8 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1946, to Feb 14 1946
and that I last saw h[illegible] alive on Feb 14 1946
Immediate cause of death: (a) Pneumonia — DURATION: 3 Days
Due to: (b) Influenza Broncho Pneumonia — DURATION: 2 Days
Due to: (c) Acute Nephritis — DURATION: 5 Days
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: Yes
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Chestertown Md Date signed: Feb 15 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

117

77RX

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01695

Reg. Dist. No. 204

1. PLACE OF DEATH:
County Kent
City or town Chestertown R.D. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ida Sawyer

3.(b) Social Security Number

4. Sex Female
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Henry Sawyer
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) Oct 14, 1872
8. AGE: Years 73 Months 5 Days 18 If less than one day ...... hrs. ...... min.
9. Birthplace Kent Co. Md
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home
FATHER 12. Name Don't know
13. Birthplace Don't know
MOTHER 14. Maiden name Don't know
15. Birthplace Don't know
16. Informant Milton Washington
Address Chestertown R.D. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 25 1946 (month) (day) (year)
Cemetery or crematory Fairlee Cemetery
Location Fairlee
18. Funeral director Asbury Hemsley
Address Chestertown, Md
19. Feb 25 1946 (Date rec'd by registrar) F. W. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946, at 11 A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...... 19...... to ...... 19......
and that I last saw h...... alive on ...... 19......
Did not attend. Investigated. Signed certificate as Deputy Med. Exam. Kent Co.

Immediate cause of death Suicide — DURATION Immediate
Due to Gunshot Wound
Due to Abdomen
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of Feb 23/46
Where did injury occur? Chestertown R.D. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Gunshot Injured at work? No

23. SIGNATURE Jack Hynes M.D. Deputy Med. Examiner Kent Co. M. D. or other
Address Chestertown Md Date signed Feb 23/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

0169 Brice

Reg. Dist. No. 200

1. PLACE OF DEATH:
County Kent
City or town near Galena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Rural Galena
(If outside city or town limits, write RURAL and give nearest town)
Street No. near Galena
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Catharine Amelia Webb

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widowed

6.(b) Name of husband or wife William Wesley Webb
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Oct 5 1867

8. AGE:

Years	Months	Days	If less than one day
78	4	1	... hrs. ... min.

9. Birthplace Kennedyville Md
(Town, county, and state)
10. Usual occupation retired
11. Industry or business
FATHER 12. Name Frank Roades
13. Birthplace Pennsylvania
MOTHER 14. Maiden name unknown Staffler
15. Birthplace Germany
16. Informant William Webb
Address Rowlen Galena Md
17. Burial Date thereof Feb 9 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Schrewsbury
Location near Kennedyville Md
18. Funeral director B R Fellows
Address Still Pond
19. February 8 1946 E. J. Mumford Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946 at 2 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1941 to Feb 6 1946 and that I last saw her alive on Feb 6 1946

Immediate cause of death	DURATION
Uremia	2 days
Due to Arteri Sclerosis + Chr. Interstitial nephritis	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Merritt Brice M. D. or other
Address Millington Md Date signed 2/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15